REMARKS/ARGUMENTS

This paper responds to the Office Action mailed October 21, 2005. Claims 1-31 are currently pending and stand rejected as being anticipated. Claims 16, 21, and 27 have been amended herein, and such amendments are supported by the specification and drawings. Examiner's rejections are addressed in turn. For at least the reasons stated below, reconsideration and allowance of claims 1-31 are requested.

Rejection Under 35 U.S.C. § 103

Claims 1-11, 13, 16-31 were rejected under 35 U.S.C. § 103(a) as being unpatentable over Lash (2001/0020229A1) in view of "A Chronic Disease Score with Empirically Derived Weights". As set forth in more detail below, the references fail to teach or suggest all the claim limitations as required by MPEP § 2143. Therefore, the rejection is unsupported by the art, and Applicants respectfully request that the rejection be withdrawn.

(a) *The References Fail to Teach or Suggest Comparing a Quantified Risk for Each Member of a Healthcare Plan*

Claim 1 recites "A method for targeting a high-risk member of a healthcare plan for proactive care, using data from a plurality of electronically stored claims of the member" including "comparing a quantified risk for each of a plurality of members of the healthcare plan." The cited references fail to teach or suggest this limitation. Rather, the reference that Examiner relies on for teaching this limitation, Lash, describes giving scores to only a subset of health plan members. See page 4, paragraph 39 ("...[A]ll of the patients in a particular sub-population have their records scored..."); see also, page 4, paragraph 41, lines 4-6, ("Those patients with a score above a certain level...can be isolated for direct intervention by the MCO."). In particular, Lash gives scores to and analyzes only members of a homogenous group with a common disease, not to each member of a healthcare plan as claimed. All subsequent analysis performed by Lash relates only to the subset of healthcare plan members and not the "plurality of members of the healthcare plan" as claimed. See, e.g., page 6, paragraph 55; see also, page 5, paragraph 48, lines 12-16.

Specifically, Lash discloses a method for predicting the likelihood that a patient diagnosed with a specific disease or medical condition will become a high user of medical services. In practice, prior to performing any analysis on the member patients in a managed care organization, the method of Lash first filters the patient members into a "homogenous sub-population" by disease or diagnosed condition, such as asthma patients or diabetic patients. Page 4, paragraph 37, lines 25-34 ("if the population is not otherwise homogeneous, it is filtered, for example on the basis of the disease or diagnosed condition of the patient to filter the population into more homogeneous sub-populations . . ."); see also, page 5, paragraph 46, lines 12-15, paragraph 48, lines 8-10; see also, Fig. 3, element 65, Fig. 3A, element 65A and Fig. 3B, element 65B. Only after patient members are filtered based on disease or condition does Lash provide scores to the subset of the members of the health plan in an effort to identify future high users of medical services from the homogenized set of patients. See page 4, paragraph 39 ("...[A]ll of the patients in a particular sub-population have their records scored in step 67, i.e., they are given a score based on the individual values for their predictive variables. The higher the score, the more likely they are to be high-use patients."); see also page 4, paragraph 38 ("Once a homogeneous population or sub-population of patients is identified, then the regression analysis program operates . . . to predict whether the patient will be a high user of medical service . . .").

Because the method of Lash first filters the patient members into a "homogenous sub-population" by disease or diagnosed condition prior to performing any analysis on the member patients in a managed care organization, the reference fails to teach comparing quantified risk for each member of a health plan as claimed. For at least the foregoing reasons, the limitations of claims 1-11 and 13 are not taught or suggested by Lash. Similarly, combining "A Chronic Disease Score with Empirically Derived Weights" with the Lash reference also fails to teach or suggest this limitation because the analysis of "A Chronic Disease Score with Empirically Derived Weights" is based a group of individuals with a specific chronic disease, see pp. 784-785, not based on a group of individuals in a healthcare plan. Reconsideration and allowance of these claims are respectfully requested.

(b) *The References Fail to Teach or Suggest Calculating a Relative Risk*

Independent claims 16, 21, and 27 each recite calculating a relative risk for each of the high-cost members, where "the relative risk for each of the high-cost members is the quotient of the member's predicted future healthcare utilization divided by an average predicted future healthcare utilization for the plurality of members." The cited references fail to teach or suggest calculating a relative risk. Rather, the reference that Examiner relies on for teaching this limitation, Lash, describes calculating an absolute score that is not relative.

Lash describes giving each patient in a particular sub-population a score "based on the individual values for their predictive variables." Page 4, paragraph 39. A score is assigned based on a regression model, but the score is not relative and the model does not include variables relating to other members in a particular group. See page 4, paragraph 38. Thus, in calculating a member's score, the method of Lash will yield an absolute score that is the same score regardless of the other members analyzed. Accordingly, the score is not relative as claimed. Moreover, the relative risk as claimed explicitly depends on other members in the analyzed group ("divided by an average predicted future healthcare utilization for the plurality of members") and therefore represents a comparison against a baseline or average risk. Lash fails to teach or suggest such a dynamic baseline for comparison.

For at least the foregoing reasons, the limitations of claims 16-31 are not taught or suggested by Lash. Similarly, combining "A Chronic Disease Score with Empirically Derived Weights" with the Lash reference also fails to teach or suggest this limitation because "A Chronic Disease Score with Empirically Derived Weights" also describes calculating absolute scores rather than relative scores. Reconsideration and allowance of these claims are respectfully requested.

Claim 12 was rejected under 35 U.S.C. § 103(a) as being unpatentable over Lash (2001/0020229A1) in view of "A Chronic Disease Score with Empirically Derived Weights" and further in view of Lutgen (2003/0167189A1), and claims 14 and 15 were rejected under 35 U.S.C. § 103(a) as being unpatentable over Lash (2001/0020229A1) in view of "A Chronic

Disease Score with Empirically Derived Weights" and further in view of Lockwood (U.S. 5,845,254). Each of these claims is allowable as depending from allowable claim 1 for at the reasons provided above.

Conclusion

No additional claim fees should be generated by this paper. However, the Commissioner is hereby authorized to charge any fee deficiency associated with this paper or the request to Deposit Account No. 04-1420.

This application now stands in allowable form and reconsideration and allowance are respectfully requested.

Respectfully submitted,

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